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Sarah Maria McNulty
Moving from the Couch to the Mat:
Clinicians and the Practice of Yoga,
Their Practice and
Recommendations of Yoga as an
Adjunct to Therapy

Abstract

The purpose of this exploratory/descriptive survey was to inquire of therapists who might or might not have a personal yoga practice, whether they recommend it to their clients as an adjunct to therapy. There has been an increasing research literature regarding the treatment of both physical and mental health issues with body work modalities that go beyond traditional “talking cure” interventions; yoga has been shown in some such studies to have positive influence on the lives of those who practice it, including clinicians themselves for purposes of self-care and avoiding burnout. Questions posed by the current survey were “Do clinicians recommend yoga to clients? Do they do so more often when they themselves actively practice yoga? Are there limitations to whether, and when, clinicians responding to this survey recommend yoga?” The study was primarily a quantitative study, conducted through an online survey provider, but qualitative data were gathered through dialogue boxes for richer context. Of the 69 respondents who completed the survey, 43 recommended yoga to clients in therapy. The therapists who are making this recommendation as an adjunct to therapy are doing so with great care and sensitivity. Those who do not make a recommendation of yoga thoughtfully addressed their reasons for the limitations they place on making recommendations of any kind.

**MOVING FROM THE COUCH TO THE MAT: CLINICIANS AND THE PRACTICE
OF YOGA, THEIR PRACTICE AND RECOMMENDATION OF YOGA AS AN
ADJUNCT TO THERAPY**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2011

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This thesis is in dedication and loving memory of Angelo F. and Esther M. Lobosco, my greatest supports and inspirations.

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Chapter I

Introduction

The next time you are standing in line at the grocery store, you may notice magazines introducing yoga as a way to reduce stress and to aid weight loss. As you drive down the street, you may notice a yoga studio opening in your neighborhood. Yoga, which was once seen as an Eastern practice, is undoubtedly making an impact on the everyday lives of Westerners -- on the health and well being of its practitioners.

Historical texts like *The Yoga Sutras* by Patanjali and *The Bhagavad Gita* have incorporated the spiritual connection of yoga. B.K.S. Iyengar described yoga in his book, *Light on Yoga*, as an Indian philosophy, and the eight “limbs” of yoga are known as paths or stages that create a union between breathe and posture, in order to accept what the universe has to offer (Iyengar, 1977). Iyengar writes about the connection of the spiritual and the physical practice of yoga. He has written several books about the postures and developed a specific form of yoga, named from him, that uses props to enhance the practice. Americans, for the most part, are familiar with the three limbs that focus on Pranayama (breathing), Dhyana (meditation), and Asana (postures).

What is yoga, precisely? Paul Salmon and his colleagues best described the aspects of yoga that are most familiar to Americans in the following quote.

The word ‘Yoga’ means ‘yoke’ or ‘union’ and connotes the interconnection of mind, body, and spirit. Yoga practice in Western contexts involves sequences of postures, called asanas, that incorporate regulated breathing and focused attention. Ongoing

practice is reported by practitioners to promote psychological well-being and a variety of physical benefits (Salmon, Luch, Jablonski, & Sephotn, 2009, p. 59.)

As someone who has benefited from yoga myself, I have developed an interest in research studies that report evidence that exercise in general, and yoga in particular, can have positive effects on stress and overall health. One study noted that a yoga practice designed for patients with COPD could assist in the improvement of physical activity with a reported decrease of respiratory distress (Donesky-Cuenco, Nguyen, Paul, & Carrieri-Kohlman, 2009). I have likewise seen articles on yoga as a form of exercise that made claims of improvement in the mental health of those who practice it. Butler and colleagues published a study outlining possible benefits that yoga could have on individuals with long-term depression (Butler, Waeldle, Hastings, Xin-Hau Chen, Marshall, Kaufman, Nagy, Blasey, Seibert, & Spiegel, 2008). A similar study from Wake Forest University School of Medicine examined a specific population, women with breast cancer, and the impact a restorative yoga practice could have out treatment outcomes (Danhauer, Mihalko, Russell, Campbell, Felder, Daley, & Levine, 2009). Clearly, if research shows such possible benefits from yoga, it would make sense that clinicians would regard it as an effective method of self-care and might recommend it to clients they see in psychotherapy.

But do they? Do clinicians, of those surveyed, recommend yoga as an adjunct to therapy? If they do make the recommendation, how many do? And do clinicians who recommend it most often – as I might expect – themselves practice yoga? Or is it a common recommendation even among those who do not themselves do so, simply because the benefits of yoga are becoming so well known? I developed an interest in conducting an exploratory/descriptive survey of practicing mental health clinicians in order to find partial answers, at least, to these questions.

The following chapter will review in more detail the research discussed briefly above as a prelude to outlining the reasons for my choice of methodology for this study and ultimately the findings of my survey.

Chapter II

Literature Review

The existing research literature supports the use of yoga as a self care modality for professionals, as well as the introduction of yoga in a psychotherapy practice, based on the success of yoga as a modality with breast cancer patients whose mental health was supported during diagnosis and treatment, and also based on the success of mindfulness yoga practices with students who are training to become therapists. Current research findings also support the joining of yoga with traditional treatments for depression and anxiety disorders. Researchers have also explored adding yoga as an intervention for those being treated for psychotic disorders.

Self Care for Professionals

Salmon and his associates wrote about the existing research on yoga and its potential impact on practitioners, noting both physical and emotional aspects of having a practice. He reported that yoga is growing in popularity in the West and is now the part of one of the most common forms of adjunct interventions in the United States, (Salmon, Lush, Joblonski, & Sephton, 2009).

For clinicians willing to invest the time and energy to become immersed in Yoga practice and philosophy, the potential payoffs are substantial. Yoga incorporates elements of traditional psychological relaxation techniques that elicit the Relaxation Response. It provides an alternative means of achieving this state, adding flexibility to one's clinical repertoire of relaxation practices. Slow, repetitive movement patterns help entrain

physiological factors (breathing synchrony, heart rate, etc.) easily disrupted by stress, creating a satisfying sense of physical integration” (Salmon, et al., 2009, p. 69).

In 2005 a study was published about the impact of yoga on the life, both personal and professional, of therapists. Valente and Marotta interviewed six psychotherapists about the impact yoga had on them; using a qualitative methodology, the researchers were able to identify themes. The group demographic included five women and one man, between the ages of 35 and 58 years old, and all of the participants identified as Caucasian (Valente & Marotta, 2005). “Four major themes have been identified from content analysis of the interviews as salient features common in the lives of these psychotherapists: internal/self awareness, balance, acceptance of self and others, yoga as a way of life” (Valente & Marotta, 2005, p. 72).

The therapists found that their practice of yoga increased their ability to be more in touch with their bodies and gave them a greater awareness of the inner workings of their bodies, which resulted in a greater “ability to monitor emotional reactivity while working their clients.” (Valente & Marotta, 2005, p. 73). The therapists reported that they were able to manage their environments in both their professional and personal lives, resulting in effectively preventing burnout symptoms. The therapists were also more accepting of themselves and others as a result of practicing yoga. They found themselves to be more empathic while working with their clients, while being less demanding in other aspects of their lives (Valente & Marotta, 2005). The researchers found that the longer the therapists practiced yoga, as in years practicing, the more likely that yoga integrated into their lives and was not something to be separated (Valente & Marotta, 2005).

As the participants stated in the Valente and Marotta study, yoga can have an impact on a healthy life style and could minimize the chance of burnout among clinicians. A quantitative

study out of Wright State University examined rates of burnout among doctorate level licensed clinical psychologists. This study did not address the possible outcomes of therapy, but rather questioned whether the rates of burnout among doctoral level clinical psychologists are higher than once perceived. The researchers found high levels of exhaustion, depersonalization, and questioning of personal accomplishment among those surveyed (Ackerley, Burnell, Holder, & Kurdek, 1998).

School settings, especially at college and university levels, appear to be an appropriate climate for yoga groups. At the Central Michigan University Counseling Center, a yoga therapy group was started to assist students, faculty and staff in the development of stress-management skills. The participants were not asked to disclose personal information; therefore, demographic information was not gathered. The researchers, however, did state that there was a wide range of ages among those who took part in the group. The researcher concluded, “Yoga tends to be viewed as an enjoyable way to cope with stress” (Milligan, 2006, p. 185). The counseling center offered a free yoga class once a week on Thursdays as part of the Yoga for Stress Management Program. The participants stated that they preferred a class offered later in the week as a chance to “decompress stress from the week, and many wanted to de-stress before the weekend” (Milligan, 2006, p. 183). Milligan found the students started to experience the faculty and staff on a more personal level as they engaged in the yoga postures, whether they struggled or were able to move easily into a posture. Another outcome was each student’s increased awareness of the ability to manage his or her own health.

Milligan describes ways to structure and facilitate a program if one would like to start a program on one’s own campus or workplace. Milligan explains the scheduling considerations and ones for finding facilitators: one trained as a yoga instructor to address some of the yoga

teachings and metaphors, and one who is trained as a counselor to consult as needed. She also addresses ensuring the availability of the programs, such as providing access to those with physical disabilities (Milligan, 2006).

Researchers from the Montana State University developed an elective course for graduate students in a master's program for counseling, called Mind/Body Medicine and the Art of Self-Care. "The underlying philosophy behind the course is that of Buddhist mindfulness as interpreted through the Mindful-Based Stress Reduction (MBSR) Program developed by Jon Kabat-Zinn (1990) and implemented at the University of Massachusetts Medical Center in 1979" (Christopher, Christopher, Dunnagan, & Schure, 2006, p. 497). Data were collected in a qualitative manner; from the class, there was a focus group of 11. The demographics of the group were eight females and three males, ranging in age range from early 20s to mid-50s. The participants' ethnicities were not disclosed (Christopher, Christopher, Dunnagan, & Schure, 2006). The students who were interviewed reported that they were more "present" and noticed an increase in their focus since taking the class. The students also credited the class with contributing to their feeling more prepared to work with clients in a therapy setting. The researchers stated that they would make the syllabus available to programs that were interested in using it. "Taking this course resulted in positive outcomes with personal functioning and also influenced students' capacities and abilities within clinical environments" (Christopher, Christopher, Dunnagan, & Schure, 2006, p. 506).

In 2008, Schure, Christopher and Christopher expanded their study into a longitudinal one over a four-year period with 33 students. The age range was similar to that in the original study, with 27 female and six male participants. The researchers disclosed the ethnicities of the student participants, with 30 students identified as White, two students identified as Japanese,

and one student identified as Native American. The elective class that was mentioned above for the 2006 study was still offered in a similar format. The students had a final journal assignment asking them to reflect on their work during the semester and on how their lives were changed (Schure, Christopher, & Christopher, 2008). The students noted not only physical changes, but also emotional ones. The students were incorporating meditation, yoga, and qigong into their practice and reported “increased comfort in with silence,” “recommending specific practices,” and “incorporating practices into therapy,” while “continuing personal practice” (Schure, Christopher, & Christopher, 2008, p. 49).

For a new therapist, there may be an increased level of anxiety around working with clients in the clinical setting. Ideally, the anxiety will decrease as the therapist continues to practice, but it can be helpful to have an added skill to manage the stress that a therapist endures while working with a client in an effort to prevent burnout.

Mental Health

In 2009 a study was published which found that yoga practice combining yoga poses, cyclic meditation (moving meditation), and corpse pose improved memory and decreased anxiety (Subramanya & Telles, 2009). The study was done on 57 males, who were assessed using standardized measures before and after a practice that consisted of cyclic meditation (CM) with postures and corpse pose, each for 22 minutes and 30 seconds a day. The CM and corpse pose practice rotated every other day. The researchers found that the participants had a significant improvement regarding a decrease in anxiety when they practiced meditation with postures (Subramanya & Telles, 2009).

In a study by Pilkinton, Kirkwood, Rampes and Richardson (2005), the authors looked at the addition of yoga in the treatment of depressive symptoms and anxiety disorders. They chose

these populations due to the frequency of these diagnoses in the United States and United Kingdom: the authors point out that the most common mental health diagnoses in both these countries are depression and anxiety. The researchers, after an extensive review of literature and multiple study groups, found that the yoga interventions could have effects that improve depression symptoms. They looked at several styles of yoga and breathing techniques and found them to be beneficial, but they were unable to state which was most effective. (Pilkinton et al., 2005).

Pilkinton et al. make a strong case for undertaking additional research for yoga as an intervention to treat those with depression symptoms. Clients who suffer from long-term depression often do not seek therapeutic help when they need it; such a delay can adversely affect clinical outcomes because the clients who could benefit from them have not had treatments available. Clients who have had long-term depression may be more likely to take part in traditional treatment modalities like medication management alone (Butler, Waelde, Hastings, Xin-Hau Chen, Marshall, Kaufman, Nagy, Blasey, Seibert, & Spiegel, 2008).

Another study published in the *Journal of Clinical Psychology* by Butler, Waelde, Hastings, Xin-Hua Chen, Marshall, Kaufman, Nagy, Blasey, Seibert, and Spiegel in 2008 observed how patients benefited from meditation style yoga in a group setting that included hypnosis and psycho-education in work with those who are chronically depressed. The participants were mostly female and came from various ethnic backgrounds, while they were mostly Caucasian/White. The researchers also noted their level of education and income. Their results are summarized in the following quote:

We found promising preliminary support for the use of these interventions to improve diagnostic status and ward off the development of further MDEs [major depressive

episodes]. We did not, though, demonstrate statistically significant improvement in overall symptom reports over the course of the study. (Butler, Waelde, Hastings, Xin-Hua Chen, Marshall, Kaufman, Nagy, Blasey, Seibert, & Spiegel, 2008, p. 815).

In the open trials of Vinyasa yoga, participants enjoyed the practice of this style of yoga, while taking their prescribed anti-depressant. It was difficult to draw specific generalizations to a larger population from the study, as it did not have a control group and only had one male participant in the study. During the orientation session, the participants "...were provided with a yoga mat and a copy of *Yoga for Depression* (Weintraub, 2004)" (Uebelacker, Tremont, Epstein-Lubow, Gaudiano, Gillette, Kaibatseva & Miller, 2010, p. 251). The participants were given free passes to a yoga studio, enough for one class per week over 12 weeks.

The research involved an observational study of participants in a group of 11 who had depression symptoms. The study was conducted with follow-up assessments over the phone after the participants participated in a yoga class during weeks two, four, and six. The participants reported that they enjoyed yoga and were able to attend most of the classes with minimal issues regarding "outside factors." The participants noted traffic, childcare and parking were some of the issues. The participants critiqued the class, with some reporting that there were some postures they did not enjoy and that there was too much "philosophy" within the class, while others enjoyed these aspects. The participants also reported that overall the book provided appeared to be helpful. The study authors argued that it would be important to pursue further research in this area (Uebelacker, Tremont, Epstein-Lubow, Gaudiano, Gillette, Kaibatseva & Miller, 2010).

Many studies that are available are based on yoga and the treatment of mild to severe mood disorders, specifically depression and anxiety, as just reviewed, but still others have considered yoga an adjunct to treatment of major mental illnesses such as schizophrenia. A study

published in 2007 by Duraiswamy, Thirthalli, Nagendra, and Gangadhar paired yoga and physical exercise with traditional treatments of schizophrenia (e.g., medication) and observed the outcomes. This study took place in India, where yoga is a common practice. One group of participants had a yoga group to attend and the other attended an exercise group. Results indicated that yoga had a greater impact on decreasing symptoms of schizophrenia than did physical exercise. Both groups showed improvement as opposed to medication management alone, (Duraiswamy, Thirthalli, Nagendra, & Gangadhar, 2007). “They were also better in their social and occupational functions and quality of life” (Duraiswamy, Thirthalli, Nagendra, & Gangadhar, 2007, p. 228).

An Australian study used yoga and relaxation techniques as an intervention for those who suffer from mild to moderate levels of anxiety. Participants were separated into two groups: one worked through various yoga postures and the other used relaxation techniques that included a guided relaxation audio recording. The researchers found that both groups reported a lower level of stress and anxiety and saw improvement in regards to stress levels when a yoga program was maintained over a long period of time, as in more than six weeks (Smith, Hancock, Blake-Mortimer, & Eckert, 2007).

Dr. Bessel van der Kolk has been a leading researcher on the practice of yoga with trauma sensitive patients. He worked with David Emerson, E-RYT on developing a yoga program to work with patients who are survivors of various types of trauma as a pilot study for research for the use of yoga with trauma survivors. Participants were either placed in a yoga class or in a Dialectical Behavior Therapy (DBT) group. It was reported that participants showed an improvement of their PTSD symptoms within eight weeks of attending a yoga class (Emerson, Sharma, Chaudhry, & Turner, 2009). The authors state that the small sample did not

permit a conclusion about statistical significance, but note “...these benefits [of yoga] may match or exceed those of the more commonly utilized DBT-skills intervention” (2009, p. 125).

The Trauma Center in Brookline, MA took great care when working with patients who were trauma survivors. The yoga teachers in the program were in special training to work with patients with trauma backgrounds. They created an environment that was welcoming and calming for the participants. The authors noted that efforts were made to tailor the regime to the trauma participants, based on the students’ physical ability, so that it would be accessible to all the participants (Emerson, Sharma, Chaudhry, & Turner, 2009).

The yoga teachers are a major influence on the comfort of the class. They are the people who will guide the class through the yoga postures; the authors were clear about how language could affect the participants’ experience of the yoga class as comfortable, and ultimately affect the impact of the presenting trauma symptoms. “Yoga is not so much about *getting students to do something* but more about *inviting them to try something*” (Emerson, Sharma, Chaudhry, & Turner, 2009, p. 126).

At Wake Forest University School of Medicine, a study followed the trend of complementary medicine and alternative medicine in treatment for breast cancer. This study showed improvements in the patients’ emotional well being after a ten-week restorative yoga class. Limitations of this study were the lack of diversity: most of the participants were white, educated and all of them were women, as is likely in cases of breast cancer (Danhauer, Mihalko, Russell, Campbell, Felder, Daley, & Levine, 2009). A quote from another study offers support for the use of yoga to achieve benefits similar to the relaxation response:

Meditation in the classical yoga tradition may be used to let go of thoughts that maintain the depressive affect. Hypnosis can be and was utilized to combine a pleasant sense of

physical relaxation with a restructuring of situations that typically exacerbate depression (Butler, Waeldle, Hastings, Xin-Hau Chen, Marshall, Kaufman, Nagy, Blasey, Seibert, & Spiegel, 2008, p. 816).

In 2009 a study was published about the use of yoga and the impact it has on patients with chronic obstructive pulmonary disease (COPD). The 29 participants who were recruited had dyspnea, shortness of breath, and they were encouraged to practice a yoga style of breathing called pranayama and various asanas, yoga postures. The participants were guided by an experienced yoga teacher and then encouraged to practice at home. The researchers assessed the heart rate, oxygen levels, pain levels, and dyspnea symptoms after each yoga session (Donesky-Cuenco, Nguyen, Paul, & Carrieri-Kohlman, 2009).

While yoga did not change the pulmonary function of the participants, the participants were able “...to walk longer without feeling as bothered by dyspnea...” and this “...may indicate an improvement in the perceived ability to control their dyspnea during exercise” (Donesky-Cuenco, Nguyen, Paul, & Carrieri-Kohlman, 2009, p. 232). Overall, the participants enjoyed the yoga practice and reported “...improved postures, relaxation, and stress reduction; improved feelings of well-being; enjoyed social interactions; pain relief; and increased awareness of breathing (Donesky-Cuenco, Nguyen, Paul, & Carrieri-Kohlman, 2009).

The studies of a qualitative nature, such as in the 2005 study by Valente and Maroota, and also the study by Danhauer, Mihalko, Russell, Campbell, Felder, Daley, and Levine in 2009, are (not surprisingly) focused on a smaller sample. The authors’ conclusions do allow for their studies not having a wide sample, and for other limitations concerning the diversity of the sample, but they did find yoga to have been helpful to their limited participant sample. Studies with a larger sample—for example, Duraiswamy, Thirthallo, Nagendra, and Gangadhar in 2007,

Butler, Waelde, Hastings, Xin-Hau Chen, Marshall, Kaufman, et al. in 2008, and Pilkinton, Kirkwood, Rampes and Richardson in 2005—suggest that yoga paired with therapy can indeed have some benefit and could readily be applied to the general population.

From the articles reviewed, it appears that different types of yoga improve emotional well being, but that some styles may be more effective than others, though further research may be needed to explore which ones are most useful and for what presenting concerns. The available research literature also shows that yoga does not have to be limited to just mental health, but also is helpful with medical ailments. This could theoretically reduce the hesitation clinicians might have in recommending yoga as a chance to improve the overall well being of patients. It would be worth exploring with the patients what they would enjoy. Exactly how yoga can assist in the management of anxiety and mood disorders needs to be explored in further research. All of the research indicated that further studies are needed to fully understand the impact of yoga and a mindfulness practice on mental health. However, the research literature just reviewed suggested to me that the value of yoga as an adjunct to psychotherapy is something many clinicians and general physicians are already applying. What was not clear to me is the extent to which those clinicians who are trained in a predominantly verbal psychotherapy – our familiar “talking cure” – are currently recommending yoga to therapy clients, and if they do so, whether this happens primarily when the clinicians are themselves practicing yoga, or even when they are not. I undertook the thesis project reported here to explore these and related issues. The following chapter will describe the method I used to derive answers to my questions.

Chapter III

Methodology

The research reported here was aimed at gathering information about the experiences of clinicians or clinicians in training who may or may not have an active yoga practice, and asked for information from both clinicians who do practice yoga and those who do not themselves practice. This exploratory study inquired about both the personal yoga practice of active clinicians and about whether they do or do not recommend yoga to their clients as an adjunct to therapy. This study was primarily a quantitative survey, but with limited qualitative data collection; the qualitative responses were elicited through the dialogue boxes provided in the survey.

Participants and Recruitment Methods

I recruited clinicians and clinicians in training, which included: social workers, psychologists, psychiatrists, or respondents from other disciplines—so long as the therapist was at least a master’s level clinician or master’s level intern. The participants were required to have an active mental health practice and be at least a master’s degree candidate in a mental health discipline. However, those with advanced degrees beyond a master’s were welcome to participate in the survey.

I recruited the primary group of participants through the American Association for Psychoanalysis in Clinical Social Work’s (AAPCSW) listserve. At the request of the Smith College School for Social Work’s Human Subjects Review Committee, I sought confirmation from the AAPCSW— of which I am a student member—that I would be permitted to send my

survey through the listserve. I contacted the listserve's moderator for permission to utilize the listserve. I was granted permission and was able to send my survey to the listserve via email. (A copy of my study's approval letter from Smith College's Human Subjects Review Committee may be found in Appendix A.) I also asked the participants to send the announcement with the survey link to colleagues who they felt would be appropriate to participate, thereby using a snowball sampling method to access participants. (A copy of the email containing the hyperlink to the survey is contained in Appendix B.)

In the past, study recruitment emails have been sent to me by AAPCSW, so I believed my email would be familiar to the participants and a feasible way of enrolling voluntary respondents. The AAPCSW not only has a membership that contains numerous clinical social workers, but also offers membership to clinicians from other disciplines in related professions. The members practice in various clinical settings and so the snowball method was an appropriate way to recruit other participants.

Data Collection

In order to find the prevalence of yoga practice and the recommendations about yoga among clinicians, I felt an online survey would be the most efficient way to collect data; unlike a small-scale qualitative study, a quantitative survey would best guarantee a large enough number of participants to offer some evidence about prevalence. Through an online survey, I could also guarantee anonymity for the quantitative responses of my participants.

My survey was a 21-question voluntary survey with structured answer choices, yet as noted above, some questions gave the participants an opportunity to express their answers in an open-ended fashion through the dialogue boxes. Such dialogue boxes provided survey participants a chance to offer, in their own words, more spontaneous and detailed accounts of

their experiences of yoga and their recommendations. (A copy of the Informed Consent that was reviewed by participants is contained in Appendix C. A copy of the survey filled out by the participants is contained in Appendix D.)

The survey was conducted online through the Survey Monkey provider, which distributed the survey via email to mental health clinicians. There was a focus on mental health practitioners, rather than those in other social science fields due to a possibly deeper understanding and opportunity to utilize yoga as an adjunct to therapy among clinicians, and the potentially greater ability treating clinicians would have to observe the effects yoga could have on an individual's well being.

The data collection proceeded from an emailed letter, introducing myself and addressing the purpose of the email and research. The email contained a hyperlink to my optional survey, allowing the participant to take the survey at his or her convenience. Once the participants clicked on the hyperlink, they were asked two screening questions to ensure that they were appropriate participants for the survey -- master's level clinicians or clinicians in training, with an active mental health practice. I obtained the participants' consent by having them read the informed consent and enter the survey only if they consented to the study's purpose and procedures.

If the participant declined to take the survey after reading the informed consent, he or she was able to exit the survey. The participant also had the option of exiting the survey at any time, and his or her questions would not be part of the data collected. However, every question that was posed did not have to be answered; respondents could choose to answer only the questions they preferred to answer without exiting the survey as a whole. Once the survey was submitted, though, that participant was not able to withdraw or remove the answers from the survey. Survey

Monkey software encrypts and then removes all identifying information about participants before sending the findings to the researcher. Therefore, it would have been impossible to identify specific surveys or responses within them in order to removed them after submission. This was clearly stated in the Informed Consent.

I was able to utilize the skip logic feature provided by Survey Monkey to ensure that participants answered the relevant questions – that is, the questions that pertained to them according to whether they themselves have a personal yoga practice and if they did or did not recommend yoga to clients. As noted above, participants had the option of answering only the questions they wished, as the questions were not required, with the exception of the screening questions. Once the survey was completed, the data were complied in my Survey Monkey account and I was able to access them when my collection was complete.

Data Analysis

Survey Monkey compiled the survey responses into an Excel file, which I sent to the Smith College School for Social Work's statistical analyst for her help producing the findings in the form of frequencies with which participants answered each question, and in cross-tabulating participants' demographic characteristics with the answers they gave.

Analysis of the participants' qualitative responses in the dialogue boxes was done using content theme analysis that I performed with the assistance of my research advisor. The analyses aimed to elucidate common and unusual themes found in the data collected. The details of the survey's quantitative results and qualitative response analyses are provided in the following chapter.

Chapter IV

Findings

As stated in the methodology chapter, the main recruitment group was drawn from the American Association of Psychoanalysis in Clinical Social Work (AAPCSW) with the potential for snowball sampling for additional recruitment. The following chapter discloses the findings of the survey. (As noted previously, a copy of the survey can be found in Appendix D).

Survey Monkey was the service provider used for accessing the voluntary survey. Again, as noted in Chapter III, with the exception of two screening questions, there was not a requirement to answer all of the questions. Sixty-nine people were screened into the survey by answering “yes” to both screening questions. All 69 of the participants are professionals in a mental health discipline who have an active practice and have an advanced degree or are candidates for an advanced degree.

Demographics

The participants were asked questions regarding their age, gender, and ethnic identity so that I could accurately characterize the diversity (or lack of diversity) in my sample. When asked about their age, the participants were able to choose answers in nine-year increments, starting at 21 and extending through 51+. Similarly, participants were given the opportunity to select their gender with options of female, male, transgender, or “other.” Participants were also given the option to state, in their own words, how they identify their own ethnicity.

The majority of the participants who took the survey was over the age of 51, female, and identified as White or Caucasian. Out of the 65 people who answered the question regarding age,

51 persons (73.9% of the answering sample) answered “51+.” Only one person answered the question that he or she was between the ages of 21-30. Six people fell into the age group of 31-40, and seven people are grouped into the 41-50 category. The group who responded to my survey was a much older than might have been expected, with only 14 people age 50 and younger.

Another 65 people, most likely the same people who answered the age question, also answered the gender question. Of those who answered whether they were female, male, transgender, or other, 54 (78.3 %) were female, with 11 (15.9%) being male. There were no answers for transgender or “other.”

There was a wide range of answers regarding the participants’ ethnicity. This particular question was open ended and the participants could individually state how they identified. The majority of the respondents (41 of the 60 answering this question) identified as “Caucasian” or “White.” Nine people skipped this answer, and only two participants identified as a person of color -- one by stating “Native American” and one “Mexican.” Several participants (17 of the 60 answering) identified as Jewish; it is difficult to know how to classify this response, as the person identifying as “Mexican” also identified as Jewish, and perhaps some referring to themselves as “Jewish” considered themselves persons of color, and others as White or Caucasian -- or *neither* “of color/White.” Several participants also identified as multiple ethnicities; in order to accurately to include all, an open dialogue box was used. As a result, the numbers do not add up to 69.

For greater clarity, Table 1 displays the age, gender, and ethnicity demographics of the survey respondents. Although with some qualifications, it is clear that the survey elicited participants who were predominantly older, female, and White/Caucasian in age, gender, and

ethnicity. Thus, the diversity of the sample responding is not wide. As stated above, please note that people identified various identities; therefore, what is listed are the responses the 69 participants gave as to their identities in their own words.

Table 1

Demographics of Participants

<i>n</i> =69		
<hr/>		
Age	21-30	1
	31-40	6
	41-50	7
	51+	51
Gender	Female	54
	Male	11
	Transgender	--
	Other	--
Ethnicity	Caucasian	25
	Jewish	17
	Protestant	3
	Mexican	1
	Native American	1
	European Descent	14
	White	16

Mental Health Training

Participants were asked what type of mental health training they completed and by answering in a dialogue box, the participants were able to expand on their additional training or note if their specific training was not listed. The participants were also asked how long they have

been practicing in their mental health field; for this response, options were zero to 31+ years in five-year increments.

When asked to identify their mental health training, the majority of the participants were Licensed Clinical Social Workers (LCSW). The participants were given a choice of LCSW, MSW Intern, Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Clinical Psychologist, and Psychiatrist. Sixty-three of the participants answered this question, while six chose not to answer. Fifty-five people responded that they were practicing Licensed Clinical Social Workers. Two participants were MSW interns. Individuals from other mental health orientations participated in this study; these identified as LPC, LMFT, and Clinical Psychologist. Each of these three professions had two respondents who identified as such, while there was no respondent who identified as a Psychiatrist. Fifty-seven participants added information about their psychoanalytic training. One person stated that he or she was a certified art therapist. Once again, the diversity of the sample was narrow with respect to a mental health training discipline, with most participants coming from clinical social work.

There were a significant number of participants who have been working in their respective fields for more than 31 years. Of the 67 participants who answered this question, 24 people have been working as a mental health therapist for more than 31 years.

To show the participants' specific mental health training, Table 2 is provided. It also clearly shows the years respondents have engaged in their respective mental health practices.

Table 2

Mental Health Training and Years of Practice of Participants

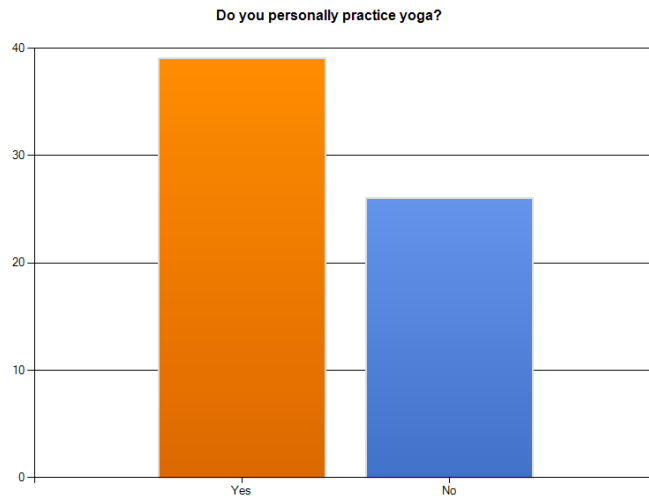
<i>n</i> =69		
<hr/>		
Mental Health Training	LCSW	55
	MSW Intern	2
	LPC	2
	LMFT	2
	Clinical Psychologist	2
	Clinical Intern	--
	Psychiatrist	--
Years in Practice	0-5	3
	6-10	6
	11-15	11
	16-20	10
	21-30	11
	31+	24

Personal Yoga Practice

Participants were asked if they have a personal yoga practice and were given an opportunity to describe the type of yoga they practice. They were asked how long they have been practicing yoga in five-year increments, zero-31+. The participants were also asked to describe their yoga practice, whether they have a home practice or attend classes in a studio, or a combination of both.

Out of the 69 participants who took the survey, 65 answered the question, “Do you have a personal yoga practice?” A little more than half of the participants, 39 (56.5%) to be precise, practice yoga. Only 26 (37.7%) answered that they do not. The following bar graph in figure 1 gives a visual of how close the numbers are of the participants whether or not they practice yoga.

Figure 1

Personal Yoga Practice of Participants

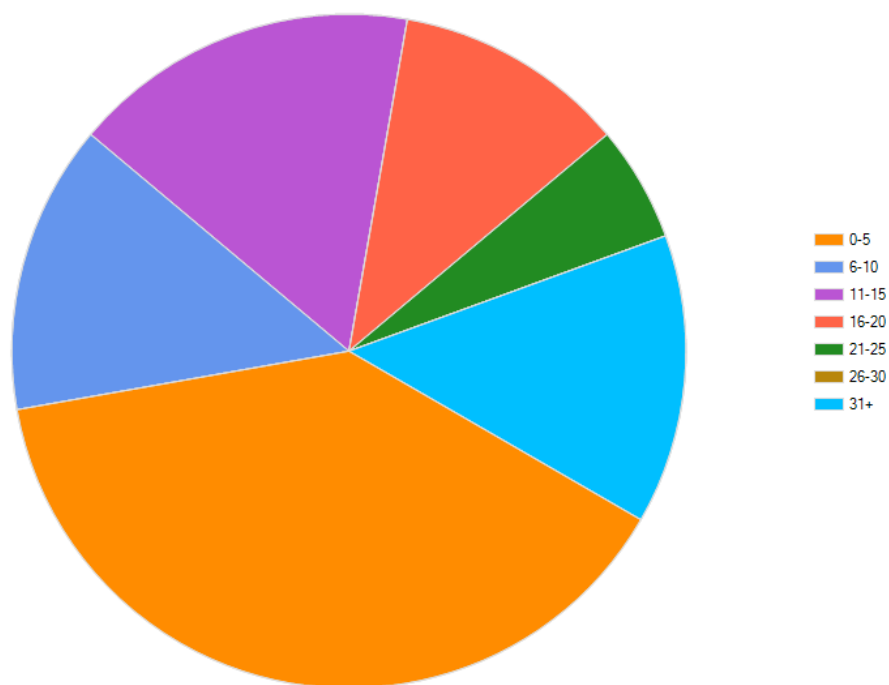
I provided a text box for participants to describe their practice. Their answers varied, from Hatha and Iyengar to having a practice but simply could not remember the Sanskrit term. Some participants simply stated that they are doing some form of yoga, “not a particular type ...gentle and restorative.” One participant stated he or she practices a limited form of yoga since having three spinal surgeries.

The 36 of 65 participants who have a yoga practice answered the question regarding the length of time they have been practicing yoga, and 14 of these 36 said that they began their practice within the last five years. Participants were given choices of 0-5, 6-10 and so on through 31+ years to describe their length of practice. Five participants (7.2%) have been practicing for over 31 years. The following figure, Figure 2, depicts the years that the participants have been engaging in a practice.

Figure 2

Years Practicing Yoga of Participants

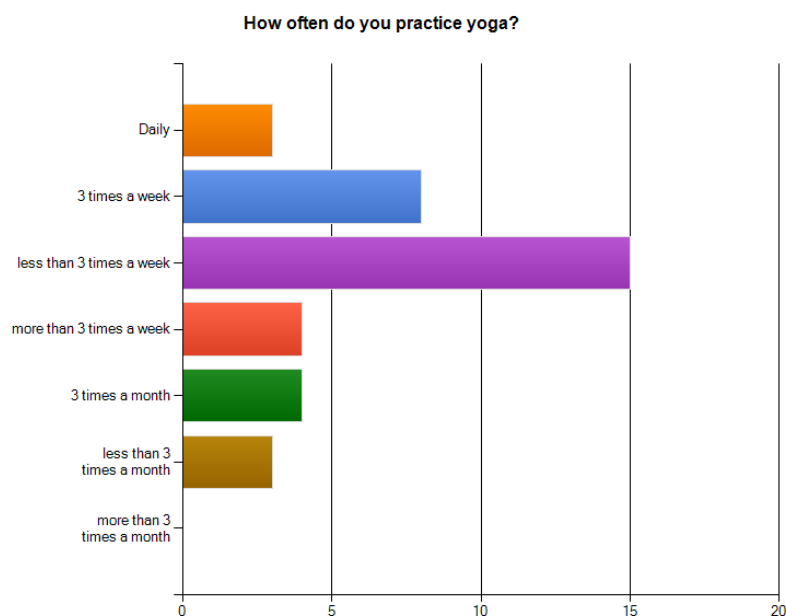
If you personally do yoga, for how many years have you been practicing?



Regarding how often they themselves practice yoga, only three of the 37 participants who answered this question practice daily. Fifteen (21.7%) practice less than three times a week, and eight (11.6%) practices three times a week. To clarify the frequencies of the participants' yoga practice, Figure 3 is provided.

Figure 3

Frequency of Participants' of Yoga Practice



Most likely it is the participants who engage in a yoga practice, the same 37 who answered the question describing his or her yoga practice, who have a home practice and/or attend classes at a studio. Those who only practice at home (N= 11) and studio (N= 10) answered at a rate of 15.9% and 14.5 % respectively. Sixteen (23.2%) reported that their yoga practice is comprised of both home practice and studio classes.

Common themes for those who have a yoga practice, and described how their personal yoga practice impacts their practice of therapy, were characterizations such as “calming,” “for relaxation,” “centering,” and “for stress reduction.” The impacts yoga had on respondents’ own therapy practice were: “awareness,” “balance,” and [making the respondent] a “better listener.” One participant pointed out that his or her yoga practice helps “better tune into my bodily countertransference.” A participant addressed the comfort yoga has provided while sitting for long periods of time, such as during a session.

With 37 people answering the questions addressing yoga and the impact it has on their therapy practice, it is also important to note that some participants did not feel that yoga impacted their therapy practice. One participant stated only that it has “some influence.”

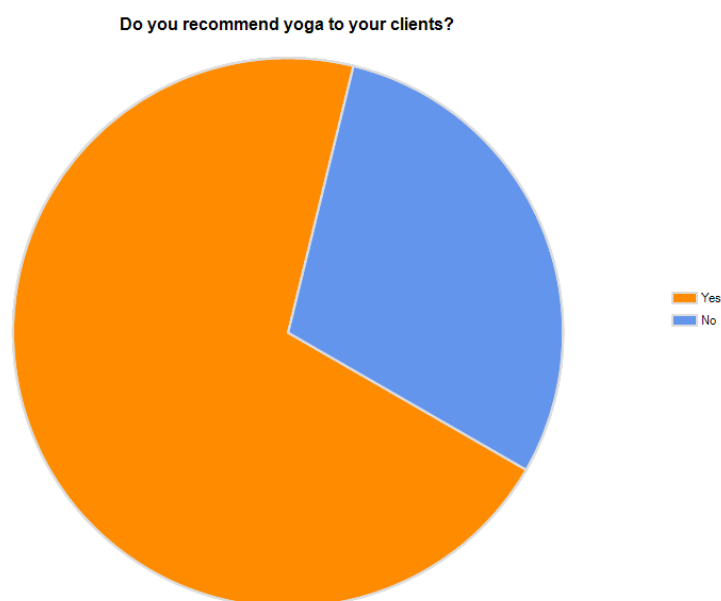
For the participants who do not practice yoga, they were able to skip the questions that pertain to a personal yoga practice and the impacts it may or not have. Twenty-six people reported that they do not practice yoga, of those 26 participants, 14 (58.3%) report that they recommend yoga to their clients. Furthermore, 21 (80.8%) of the participants who do not have a personal yoga practice stated they have considered yoga.

Recommendations of Yoga to Clients

All the participants were asked if they recommend yoga to their clients and if they did make the recommendation of yoga, under what circumstances they did so. They were asked to explain in a dialogue box what their recommendations were like, or how they would make a yoga recommendation. Participants were also asked to describe any limitations to recommending yoga in an open-ended dialogue box. Not only were participants asked about yoga, but also if there were other recommendations made, for instance: meditation, relaxation techniques, aerobic activity, or other, as to supplement therapy.

Out of the 69 participants in this study, 61 answered the question about whether or not they recommend yoga to their clients. Of those who answered, 43 (62.3%) reported that they recommend yoga to their clients. Only 18 stated they do not make the recommendation of yoga to their clients as an adjunct to therapy. This is clearly stated in the following pie chart in Figure 4.

Figure 4

Participants' Recommendation of Yoga to Clients

The participants addressed various reasons why they would make the recommendation and their reasons focused on stress reduction and anxiety reduction. These comments were obtained through an open-ended dialogue box.

Some clinicians do not make recommendations to clients as a rule; therefore, it could be expected that some survey respondents would say that do not recommend yoga. Not all participants responded to this item; 43 acknowledged whether or not they experienced limitations to encouraging their clients to engage in yoga. Although only 12 participants (17.4%) stated that there were no limitations to their recommending yoga, 31 (44.9%) stated there are limitations. A common theme that came in the explanations of those who answered this item were those of sensitivity and a reluctance to “push” anything on their clients. Some participants stated that they recommended it in a very general, non-judgmental manner.

One participant brought a valuable point to light, “I don’t recommend to children and teens because there is limited access to affordable yoga and it is less realistic for them.” This participant hereby addressed an element of access and affordability with regard to yoga that will be addressed further in the DISCUSSION chapter following. A particularly sensitive respondent’s comment about recommending yoga was “ I try to make sure my clients realize I am not ‘sending them away’ nor giving up, but adding to their repertoire of coping.”

Only six participants, out of the 40 who answered this question, reported they recommend yoga when their practice is regular. Almost half (49.3%) did not find that their practice had a bearing on their recommendation of yoga to their clients.

Many reported that they have been recommending yoga for years. One participant explained that he or she recommends yoga when it feels right to do so. A participant also reported that it is easy for a meditative and yoga practice to lapse when life gets busy, but another participant offers the option to female clients to take the women’s yoga class that his or her clinic offers.

Participants were also given an opportunity to answer if there was another form of activity besides yoga that they recommend. Thirty-eight people checked that they recommend yoga and 40 stated they suggest relaxation techniques to clients; another 34 recommend aerobic activity. Forty-eight participants addressed the other techniques in an open-ended fashion, by answering with answers such as physical activity, mindfulness, community involvement, and creative outlets, such as writing.

For those who do not recommend yoga (11 participants answered this question), seven people reported that they have not read relevant research on the benefits of the use of yoga as an

adjunct to therapy, while four participants answered that they lacked the personal experience to recommend yoga.

For other participants who do not recommend yoga, they stated they do not necessarily feel that it is because of not knowing the possible benefits of yoga, but more as a part of their general practice to make limited recommendations, instead fostering what the client is interested in. Since the primary group was psychoanalytically trained clinicians, traditionally, within this practice recommendations are not made; many reported they did not. Other participants are concerned with imposing personal beliefs on their clients, and one identified that yoga was a possible supplement, but the recommendation focused on by this therapist was helping the client explore his or her options for self-care.

Sixty of the participants in this study reported that they are aware of their clients' yoga practice. Of those who are aware of their client's personal yoga practice, 44% carry a caseload with up to 10% of practicing yogis.

These findings will be discussed further in the next chapter, along with a critique of the survey itself and suggestions as to how this preliminary study could be improved upon, with ideas for further research related to this topic.

Chapter V

Discussion

The purpose of this exploratory study was to find out whether or not therapists were recommending yoga as an adjunct to therapy, whether the tendency to recommend yoga varied depending on the therapist's having a personal practice of yoga, and whether any of the demographic characteristics of the respondent group correlated with their responses to items asking about their recommendations and their own personal practice of yoga. Over half (56.5%) of the 69 therapists who responded to my survey do make the recommendation of yoga to their clients as a supplement to therapy. Per these therapists' reports, the recommendation was taking place when it was clinically appropriate. Participants said that making the recommendation requires a rapport with the client and it needs to be time sensitive, made when it can part of the dialogue taking place during the therapy session. Therapy is purposeful and so is yoga; I found that the tendency for my participants making recommendations about yoga was also to make this recommendation thoughtfully and carefully.

One therapist noted that he or she made it clear to clients that this recommendation was not an abandonment of them; therapy would continue, but yoga could be a useful adjunct to talk therapy. Some reported that their clients might not be able to handle the silence that yoga could provide; perhaps, in such cases, the thoughtful clinician decided to omit a recommendation that would not be developmentally appropriate or otherwise timely. Some therapists surveyed also pointed out that they were working with clients who were not interested in yoga and therefore did not make the recommendation. It needs to be recognized that yoga is not for everyone and

there are some clients who would not be open to developing a yoga practice. Yoga tends to be an introspective practice and awareness of the client is important to the therapists that I surveyed; not surprisingly, they wanted to remain respectful of their clients.

Limits to When Therapists Might Recommend Yoga

Some of the participants addressed the limitations that recommending yoga could have, such as financial strain or lack of access. It was a concern of therapists that while the recommendation could provide some benefit, it is counterindicated at times to make such a recommendation to children and adolescents because of transportation issues and lack of funding.

Expected and Unexpected Findings

My study reflected the research literature in terms of the respondents' demographics. Many earlier studies about yoga reported that the majority of their sample's participants identified as female. The age ranges in earlier studies, however, varied more than mine did. The overall demographics of my respondents were surprisingly narrow: the core group of those surveyed was female, over the age of 51, White/Caucasian, and were practicing clinical social workers (as opposed to being therapists from other disciplines), and most had a personal yoga practice. Whether or not therapists from other groups would recommend yoga to clients to the extent that those in my sample did is impossible to say, given that the sample is limited and not representative. For the findings in my own and other studies to be generalized to a wider population, a larger and more diverse group would be needed.

However, it is interesting that so many studies I have found are not diverse with respect to gender or ethnicity: in the U.S. and U.K. studies reported to date, women and those who identify as white are overrepresented. Is it actually possible that in the United States, at least,

yoga is something predominantly engaged in by white women? The respondents in the current study certainly fit this very lopsided picture.

As I expected, the majority of participants who agreed to complete my survey have a personal yoga practice. Many participants reported that their yoga practice was beneficial in their life and therapy practice. It was also a form of self-care that has been a positive influence in preventing burnout within the helping profession.

My initial application to the Smith College School for Social Work Human Subjects Review Committee for approval of my study elicited a recommendation that I should limit my study to those who *do* have an active yoga practice, because only those therapists would be likely to respond to my survey and would recommend yoga to clients. On the contrary, I found that *not* having a yoga practice was not necessarily an indicator of whether or not a therapist would suggest yoga to supplement therapy. Nearly a quarter of my participants did not have a yoga practice. Of those, 58.3% nevertheless did recommend it to clients.

Furthermore, I did not find that therapists make the recommendation of yoga more often when their practice is consistent. The frequency of therapists' yoga practice did not impact them if they recommend yoga as a supplement to therapy. One participant stated, "Even when I am slack, I know that this is likely to be helpful [so] that I do not let my own omissions get in the way of recommending it to others." A therapist nicely captured a similar thought specifically: "it is really independent of my practice." Another therapist reported making the recommendation "when it feels right." I see this tendency to be client focused and sensitive. Therapists tend to make the recommendation of yoga as an adjunct to therapy when it is clinically appropriate, and while yoga tends to inform the practice of therapists, it does not dictate it.

Based on the information gathered from the dialogue boxes, therapists take great care when making a recommendation of something, whether or not it is yoga, to complement therapy. As referred to earlier, when a recommendation was made, this group strove to make it always in the best interest of the client, and to assist rather than to hinder the progress of therapy.

The type of training of the participants, as in additional training beyond a master's degree, was influential: if a given therapist made a recommendation to a client to consider adopting a yoga practice, that therapist tended to have training beyond the master's degree. Eleven participants noted they had undertaken additional psychoanalytic training.

Most of the participants who took the survey had some experience with yoga; they ranged from those who had taken their first class within the last year, to having had a yoga practice for thirty years. Most of the survey participants have a fairly frequent practice; they practice yoga at least weekly. Their practice of yoga could likely be in a class or a home practice. For those who don't have a yoga practice (n=26), some have considered it (n=21). One possible explanation is that yoga is becoming more popular and people are becoming more open to the practice of yoga. Assumingly, one participant said she or he has been "encouraged" by friends to start a yoga practice, while she or he has been recommending for years.

Limitations of the Current Study

Out of thousands of therapists in the country, I surveyed only a few and of those few, psychoanalytically trained therapists might be expected to focus more on talk therapy as a cure. By opening up the survey and seeking out other listserves that could potentially recruit therapists from other orientations, such as Cognitive Behavioral Therapists, would the numbers of therapist who recommend yoga as an adjunct to therapy increase along with the percentages?

Implications for Future Research and Policy

The reality that therapists sometimes do not recommend yoga despite their belief that it could be helpful -- due only to clients' inability to find funding or transportation to access yoga -- is concerning. This suggests that future policy decisions could be useful in making yoga available to those who are interested; in my own view, refraining from recommending yoga should not have to happen because one's clients are unable to afford it. When recommending other activities that would support the therapy to clients, like exercise, these too should be available to regardless of socioeconomic status.

There should be further research regarding the intersection of yoga and therapy. These research findings clearly imply that yoga and therapy are quite compatible and are starting to intersect. The main goal of yoga is to improve the way people feel, as one participant stated, and to have inner focus and calm. A question for the future is how best can yoga be incorporated into therapy. The findings of this study also suggest that yoga is assisting in the "self-care" aspects of therapists' personal practice. Another way to further this research is to explore whether it is taking place during a session. Are more therapists becoming certified to teach yoga? And if they are, are therapists being trained specifically to work with certain populations, as recommend by The Trauma Center in Massachusetts, which offers a focused training to those who will be working with trauma survivors?

Meditation is also a reported practice by those in this study, and a few state that it is hard to separate the two. There are also other forms of mind/body practices, such as qigong or tai chi, and as these become more popular, research regarding their usefulness as therapy adjuncts could be valuable. Patrick Dougherty, M.A., L.P. is a qigong master and analytically trained psychotherapist who says "The good news is that many Western psychotherapists and physicians

have begun to get seriously interested in the broader questions about how people heal,” (2007, p.13).

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Appendix A

Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 8, 2010

Sarah McNulty

Dear Sarah,

Your revised materials have been reviewed and we are now able to approve your study. We wonder if you will get many clinicians who do not practice yoga and do not recommend it. You may get a few who don't practice it but recommend. It will be interesting to see.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ann Hartman / Shaw', written over a horizontal line.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Survey Email

I am Sarah McNulty, a graduate student at Smith College School for Social Work. I am currently interested in conducting an online survey of clinicians for my Master's thesis. If you are a clinician or clinician in training currently in active mental health practice –whether you are a clinical social worker, clinical psychiatrist or psychologist, or a member of another mental health discipline -- I am interested in asking you if you practice yoga yourself, and if you recommend it to clients. Even if you do not have a yoga practice, I hope that you will agree to take this survey; I am extremely interested in your thoughts and experiences.

If you are interested in completing my survey, here is the internet link to use it access it. Once you enter this survey, you will be asked if you are a clinician or clinician in training and therefore eligible to take this survey, and you will be asked to review the study's purposes and other aspects to obtain your informed consent to participate. If you know of any other clinicians or interns who might be appropriate for my study, would you please let them know about it, particularly psychologists and psychiatrists and other clinicians who may not be social workers?

Thank you,

Sarah McNulty
MSW Candidate
Smith College School for Social Work

Appendix C

Informed Consent

Dear Participant,

My name is Sarah McNulty. I am a second year student in the Master's of Social Work program at Smith College in Northampton, Massachusetts. I am conducting an online survey of clinicians, wanting to learn more about whether you practice yoga, whether you do or do not recommend it for your clients, and why or why not. This survey will be part of the research I conduct for my master's thesis, and may be used for future presentations and publications.

I am interested in having you complete my survey if you are an actively practicing clinician or master's level clinical intern with an interest in responding to questions about whether you include yoga as a recommended practice in your clinical work, and whether you practice yoga yourself or not. If you fit these criteria, you could be helpful for my study. If you are willing to participate, you would complete an online survey through Survey Monkey; the survey will take no more than 30 minutes, but may be briefer depending on the comments you choose to add. I will also ask you a few demographic questions so that I may characterize my sample in the thesis report; as with all questions in the survey, these are optional.

I do not anticipate significant emotional discomfort for you in completing the items in this survey. Given that you are a master's level clinician or intern, I expect that you will have adequate personal referral resources should you experience discomfort and desire assistance. Although I am not able to offer financial compensation for your participation, I hope that there will be some benefit to you in having the chance to reflect on your practice, and to add to knowledge about yoga as either a part of that or not, and for what reasons; when the report is written, you will also be able to read about other clinicians' responses, as my completed thesis report will be available online through the Smith College Library website.

Survey Monkey strips all identifying information about the person completing the survey from the responses before these are sent to the researcher who designed the survey. Therefore, not even I will ever know which individuals have completed the survey, and which responses belong to any participant. The responses will be compiled in an MS Excel file and sent to my thesis advisor and the statistical analyst at Smith College School for Social Work. Because of the special circumstance with an encrypted internet survey, your quantitative responses to the survey items will be not merely kept confidential, but will truly be anonymous. If you choose to add brief written narrative comments to the survey using the comment boxes supplied after quantitative items in the survey, any identifying information in your comments will be carefully disguised if used in the thesis report itself, or in any later presentations or publications, to protect your confidentiality. Any material gathered for my thesis will be stored in a secure location for a period of three years, which is required by federal guidelines. In the event that these data need to be maintained for a period of more than three years, they will continued to be stored in a secure location, and all data will be destroyed when no longer needed.

Please note that your participation in this survey is completely voluntary and you may chose to exit the survey at any time. You may also choose to omit answering certain questions without exiting the survey entirely. In the event that you do withdraw from the survey, your data will not be retained, but will be erased automatically as you exit. You will not be able to withdraw from the research after you have submitted your survey; due to the nature of Survey Monkey and the encrypting of the information, I will not have a way of deciphering which are your answers and which belong to others.

If you have further concerns or wish to have other information about the study, please feel free to contact the Chair of Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you,

Sarah McNulty
MSW Candidate
Smith College School for Social Work

BY ENTERING AND COMPLETING THE SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION ABOUT THE STUDY AND YOUR RIGHTS AS A PARTICIPANT, THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS, AND THAT YOU AGREE TO PARTICIPATE.

Appendix D

Survey

1.

1. What is your age?

- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51+

2. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Other

3. How do you identify your ethnicity?

4. What is your mental health training?

- ☐ Licensed Clinical Social Worker
- ☐ Provisionally Licensed Clinical Social Worker
- ☐ MSW Intern
- ☐ Clinical Intern
- ☐ Licensed Professional Counselor
- ☐ Licensed Marriage and Family Therapist
- ☐ Clinical Psychologist
- ☐ Psychiatrist

Other (please specify)

5. How many years have you been practicing therapy?

- ☐ 0-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21-30
☐ 31+

6. Do you personally practice yoga?

- ☐ Yes
☐ No

If so, what type?

2.

7. If you personally do yoga, for how many years have you been practicing?

- ☐ 0-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21-25
- ☐ 26-30
- ☐ 31+

8. How often do you practice yoga?

- ☐ Daily
- ☐ 3 times a week
- ☐ less than 3 times a week
- ☐ more than 3 times a week
- ☐ 3 times a month
- ☐ less than 3 times a month
- ☐ more than 3 times a month

9. How would describe your own personal yoga practice?

- ☐ Home practice
- ☐ Studio
- ☐ Both, home and studio

10. What impacts does your personal yoga practice have on you?

11. How would you describe the influence of your own practice of yoga on your therapy practice?

12. If you do not have a personal yoga practice, have you considered yoga?

- ☐ Yes
- ☐ No

13. Do you recommend yoga to your clients?

☐ Yes

☐ No

3.

14. If so, under what conditions do you recommend yoga?

15. If you recommend yoga to your clients, are there limitations to your doing so?

☐ Yes

☐ No

16. If you do, what are some of the limitations of doing so?

17. If you recommend other interventions, what are they?

(Please check all that apply)

☐ Meditation

☐ Relaxation Techniques

☐ Aerobic Activity

Other (please specify)

18. Do you find that you recommend yoga more often when your practice is regular?

☐ Yes

☐ No

Please feel free to elaborate on your answer

19. If you do not recommend yoga to your clients, what are some of the reasons?**(Please check all that apply)**

- ☐ I have not read relevant research literature about the efficacy of yoga.
- ☐ I have read some research about the documented benefits of yoga but did not find it convincing.
- ☐ I find the evidence in favor of yoga compelling but have not recommended it because of lack of personal experience of its usefulness.
- ☐ I have recommended yoga in the past, but have ceased to recommend it because clients did not often accept my recommendation and follow through with yoga.

Other (please specify)

20. Of the clients you see, what percentage would you say are actively practicing yoga?

- ☐ 0-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61-70
- ☐ 71-80
- ☐ 81-90
- ☐ 91-100

21. Is there anything that you feel would be helpful for my research about the topic of the combining yoga and psychotherapy that I have not asked about?